ReLive PHYSICAL THERAPY | Patient Intake Forms

PATIENT INFORMATION

Legal Name: _____ **Date of Birth:** _____ / _____ / _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip Code)

Gender: ☐ F ☐ M ☐ N/A **Marital Status:** ☐ Married ☐ Divorced ☐ Single ☐Widow/Widower ☐Domestic Partnership

Race/Ethnicity: ☐ Caucasian (White) ☐ Hispanic or Latino Origin ☐ Eskimo/Inuit ☐ Declined
☐ African American ☐ Asian ☐ Native American ☐ Other: _____

Cell Phone: (_____) _____-_____ **Home Phone:** (_____) _____-_____ **Email:** _____

To receive appointment reminders via text messages, please check here: ☐

Preferred Method of Communication: ☐ Cell Phone ☐ Texting ☐ Email ☐ Home Phone

How did you hear about ReLive Physical Therapy? *(select all that apply)*
☐ Live/Work Close ☐ Physician Referral ☐ Social Media ☐ Community Event
☐ Former Patient ☐ Family/Friend ☐ Internet Search ☐ Insurance Referral

Primary Language: ☐ English ☐ Spanish ☐ Russian ☐ Polish ☐ Other: _____ **Do you need an interpreter?** ☐ Yes

MEDICAL HISTORY

Your Height: _____ ft _____ in **Your Weight:** _____ lbs **Age:** _____ years

In this injury related to? *(select all that apply)*
☐ Work Injury ☐ Car/Motor Accident ☐ Other Liability/Potential Lawsuit
☐ Chronic Pain/Condition ☐ Pre-/Post-Operative (Surgery) ☐ Not Applicable

Date of Injury/Symptoms: _____ / _____ / _____ *(approximate date, if unknown)*
Date of Surgery: _____ / _____ / _____ *(if applicable)*

Involved Body Part(s) and/or Condition(s): *(select all that apply)*
☐ Neck/Upper Back ☐ Shoulder ☐ Hip/Pelvic ☐ Ankle/Foot ☐ Balance/Vestibular
☐ Middle/Lower Back ☐ Elbow/Wrist/Hand ☐ Knee ☐ TMJ ☐ Women's Health

Current Pain Level: *(circle number)* *(No Pain)* 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 *(Worst Pain)*

Worst Pain Level: *(circle number)* *(No Pain)* 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 *(Worst Pain)*

Best Pain Level: *(circle number)* *(No Pain)* 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 *(Worst Pain)*

Symptoms Status:
☐ Getting Worse
☐ No Change
☐ Getting Better

Symptoms Patterns: *(select all that apply)*
☐ Come and Go ☐ Worse w/ rest ☐ Better w/ rest ☐ Worse in morning ☐ Lingers after onset
☐ *Constant* ☐ Worse w/ activity ☐ Better w/ activity ☐ Worse in evening ☐ Other: _____

MEDICAL HISTORY CONTINUED

Symptoms Description: *(select all that apply)* ☐ Dull/Achy ☐ Sharp ☐ Numbness ☐ Shooting ☐ Tight ☐ None ☐ Burning ☐ Throbbing ☐ Tingling/Pins ☐ Radiating ☐ Stiffness ☐ Other: _____

Treatment Received for Condition: ☐ Chiropractic ☐ Injections ☐ PT/OT ☐ Acupuncture ☐ None ☐ Other: _____
(select all that apply)

Special Tests Performed: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ EMG/NCV ☐ None ☐ Other: _____
(select all that apply)

Do you have or ever had any of the following conditions: *(please mark one box per item)*

	No	Yes	N/A
Smoking / Tobacco	☐	☐	☐
Diabetes	☐	☐	☐
Heart Condition	☐	☐	☐
High Blood Pressure	☐	☐	☐
Chest Pain	☐	☐	☐
Stroke	☐	☐	☐
Kidney Condition	☐	☐	☐
HIV / AIDS	☐	☐	☐
Cancer	☐	☐	☐
Tuberculosis	☐	☐	☐
Circulation / Vascular Problems	☐	☐	☐
Peripheral Neuropathy	☐	☐	☐
Unexplained Weight Loss	☐	☐	☐
Double Vision	☐	☐	☐
Night Sweats / Night Pain	☐	☐	☐
Metal Implants	☐	☐	☐
Heart Surgery	☐	☐	☐
Numbness / Tingling	☐	☐	☐
Shortness of Breath	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Pacemaker	☐	☐	☐

	No	Yes	N/A
Bladder / Bowel Problems	☐	☐	☐
Groin Numbness	☐	☐	☐
Arthritis	☐	☐	☐
Osteoporosis	☐	☐	☐
Psychological Condition	☐	☐	☐
Seizures / Epilepsy	☐	☐	☐
Depression	☐	☐	☐
Ringing in Ears	☐	☐	☐
Allergy to Latex (Gloves)	☐	☐	☐
Other Allergy	☐	☐	☐
Head Injury	☐	☐	☐
Obesity	☐	☐	☐
Chronic Pain / Fibromyalgia	☐	☐	☐
Chronic Headaches	☐	☐	☐
Fractures	☐	☐	☐
Fever / Nausea	☐	☐	☐
Weakness / Fatigue	☐	☐	☐
Difficulty Maintaining Balance / Vertigo	☐	☐	☐
Confusion / Memory Loss	☐	☐	☐
Blood Clot / DVT	☐	☐	☐
Are you Pregnant?	☐	☐	☐

List any Surgeries / Procedures / Major Injuries	Date

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MEDICATIONS LIST

Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking:

Medication Name	Dosage	Frequency	Route of Administration (Oral, Ointment, Patch, Injection, Inhaler)

WORK INFORMATION *(Required for Workers' Compensation)*

Occupation:_____ **Last Date of Work:** _____ / _____ / _____
(if applicable)

Employer:_____ **Employer Number:** (_____) _____-_____

Address:_____
(Street) (City) (State) (Zip Code)

EMERGENCY CONTACT INFORMATION

ER Contact Full Name: _____ **ER Contact Number:** (_____) _____-_____

ER Contact Relationship: Spouse Parent Child Sibling Family Friend Neighbor Other: _____

REFERRING PHYSICIAN INFORMATION

Physician's Full Name:_____ **Physician's Group:** _____

Physician Phone Number: (_____) _____-_____ **Physician Fax Number:** (_____) _____-_____

Next Follow-up Date: _____ / _____ / _____ or Not Scheduled

Primary Care Provider:_____

HEALTH INSURANCE INFORMATION

Primary Insurance Company: _____ **ID #** _____ **Group #** _____

Policyholder Full Name: _____ **Relationship:** _____ **DOB:** ____ / ____ / _____

Secondary Insurance Company: _____ **ID #** _____ **Group #** _____

Policyholder Full Name: _____ **Relationship:** _____ **DOB:** ____ / ____ / _____

Do you have an attorney? ☐ Yes

Attorney Name: _____ **Law Firm Name:** _____

Attorney Phone Number: (_____) _____-_____ **Attorney Fax Number:** (_____) _____-_____

CONSENTS AND ACKNOWLEDGMENTS

Please carefully read the following statements and initial where indicated.

Email Communication
I agree to receive communication regarding appointment updates and marketing communication from ReLive Physical Therapy at the provided email address.

_____ *Initial Here*

Release Confidential Patient Information
I give permission to the following person(s) to receive detailed verbal information regarding appointments, medical care, billing, and payment information. I understand this DOES NOT authorize the disclosure of my written health information.

☐ I wish to decline authorization for others to communicate with ReLive Physical Therapy on my behalf.

_____ *Initial Here*

Authorized Individual Full Name: _____ **Relationship:** _____

Authorized Individual Full Name: _____ **Relationship:** _____

Consent to Treat
I hereby consent to, and authorize ReLive Physical Therapy, my physical therapist, occupational therapist, and other health care professionals and assistants who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist, occupational therapist, or other healthcare professionals. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin, soreness after treatment and hematoma, including, without limitation, myofascial decompression and blood flow restriction, Instrument Assisted Soft Tissue Mobilization (IASTM), Asytm® or Graston Technique®, Dry Needling, Video Throwing Analysis, and Video Gait Analysis. I understand that it is my responsibility to inform my physical therapist, occupational therapist, or other health care professional if I experience any discomfort or pain during any treatment, or if I have other unresolved concerns around my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury.

_____ *Initial Here*

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CONSENTS AND ACKNOWLEDGMENTS

Please carefully read the following statements and initial where indicated.

Patient Communication Acknowledgment
I understand ReLive Physical Therapy may call my cell/home/work number or alternative number and leave a voicemail or in-person in reference to appointment reminders, insurance or billing items. I also authorize the release of appointment information left in a voicemail, answering machine, email, or text message and understand that there is some level of privacy risk associated with these forms of communication.

_____
Initial Here

Appointment Attendance Acknowledgment
I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and I understand that cancellation of, or failing to keep, an appointment with less than 24 hours' notice will result in a cancel/no show fee of $40. If you do not show for your regular appointments, or are inconsistent in attending therapy, you may be discharged from therapy. Your physician and/or case manager will be notified and you will not be able to return to therapy without a physician's new order.

_____
Initial Here

Notice of Privacy Practices
I acknowledge that I have received ReLive Physical Therapy's Notice of Privacy Practices. ReLive Physical Therapy's Notice of Privacy Practices (NPP) provides information about how ReLive Physical Therapy may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patient's Rights section describing your rights under the law. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our NPP, please contact our main office at (708) 390-3362.

_____
Initial Here

FINANCIAL RESPONSIBILITIES

The follow statements explain the patient's Financial Responsibilities, which we ask you to carefully read and sign.

Insurance Plans
We participate in most insurance plans; however, we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with the pre-authorization of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary by some medical insurance companies.

_____
Initial Here

Responsibility for Payment
All co-payments and self-pay services (i.e., Astym®, Graston Technique®, VGA, VTA, etc.) are due at the time of service. I acknowledge that in consideration of the services provided to me by ReLive Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide ReLive Physical Therapy with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I agree to pay any such amounts which are my responsibility. I understand that ReLive Physical Therapy will bill my personal insurance carrier as a courtesy, but that I am ultimately responsible for any amounts owed. If formal collection procedures become necessary, I am responsible for any additional costs incurred as a result of such collection procedures.

_____
Initial Here

Assignment of Benefits
I hereby authorize my insurance benefits to be paid directly to ReLive Physical Therapy. I understand that I am fully responsible for all charges whether paid or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also authorize ReLive Physical Therapy or insurance company to release my information required to process my claims. If applicable, I authorize assignment of Medicare benefits and Medigap payments directly to ReLive Physical Therapy.

_____
Initial Here

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

► _____ _____

Printed Name of Patient | **Signature of Patient or Legally Responsible Person** | **Date**